CYPRESS THERAPY CENTER
150 S. E. Plaza Roadway
Winter Haven, FL 33880
Phone: (863) 295-7799
Fax: (863) 295-7757

Patient Name: _____ Patient Phone: _____

Diagnosis: _____

Physician (print): _____ Date of Onset: _____

Special Instructions/Precautions: _____

PT ____ OT ____ Frequency and Durations: _____ x per week for: _____ weeks.

Other: _____

EVALUATE AND TREAT

☐ **Pulmonary Rehab**
☐ **Cardiac Rehab**
☐ **Accupunture**

Manual Therapy
☐ Neuro Muscular Re-education
☐ Manual Traction
☐ Joint Mobilization
☐ Soft Tissue Manipulation
☐ Gait Training
☐ Balance Training

Modalities
☐ Moist Heat
☐ Cryotherapy
☐ Ultrasound
☐ Iontophoresis
☐ Phonophoresis
☐ Electrical Stimulation

Education
☐ Posture Instruction
☐ ADL Training
☐ Body Mechanic Instruction
☐ Neutral Spine Instruction
☐ Biofeedback

☐ **ROM Restrictions**
_____

Spine Management
☐ Cervical
☐ Lumbar

☐ **Vestibular Rehabilitation**

☐ **Social Services**
(This patient needs social services)

☐ **Speech Language Pathology**

Respiratory Therapy
☐ Education/Breathing Retraining
☐ Strength Endurance Training
☐ Maintenance Program

☐ **Other (specify)**
_____
_____
_____
_____
_____
_____
_____

Physician Signature: _____ Date: _____

My signature authorizes this treatment to be medically necessary.

PLEASE FAX SCRIPTS TO OUR OFFICE AT 863-295-7757

CYPRESS SLEEP CENTER
150 S.E. Plaza Roadway
Winter Haven, Florida 33880

PLEASE FAX TO: (863) 295-7757
OR CALL: (863) 295-7799

Please send H&P or current office notes to warrant sleep studies when available.

Contact Person: _____ Phone Number: _____

PHYSICIAN'S RX ORDER FOR SLEEP STUDY

Patient Name: _____ D.O.B. ____ / ____ / ____

Address: _____ City: _____ State: _____ Zip : _____

Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

Insurance: _____ ☐ HMO ☐ PPO ☐ Other _____

Id No.: _____ Group No.: _____

Ins. Phone No.: _____ Auth No.: _____ No. of visits____ Exp. Date ____ / ____ / ____

Patient's Chief Complaint: ☐ Obesity ☐ Loud Snoring ☐ Witnessed Apnea ☐ Excessive Daytime Sleepiness

☐ Other _____

Type of Study Requested (CPT-4)

☐ 95810 Baseline Study w/CPAP Titration if qualifies

☐ 95811 CPAP Titration Study

☐ 95811 Solit Night Study

☐ 95811 Re-Titration CPAP study

(Last Titration Study performed _____)

Reason for Testing (ICD-9)

☐ 780.53 Hypersomnia with Sleep Apnea

☐ 780.54 Other Hypersomnia

☐ 780.57 Other & Unspecified Sleep Apnea

☐ 780.50 Sleep Disturbance, Unspecified

☐ Other _____

☐ **Special Instructions:** _____

Physician's Signature: _____ Date: ____ / ____ / ____

Thank you for your referral.
We will contact you upon receipt of this information.